

MEDICAL RECORD**CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>		
Date:	Vasectomy - Day of procedure:		
Time:	Pre-op vital signs:		
	Allergies:		
	Anxiety level prior to procedure: <input type="checkbox"/> 1 - Low <input type="checkbox"/> 2 - Medium <input type="checkbox"/> 3 - High		
	If anxiety level is 3, health care provider will be notified prior to procedure.		
	Pain level: No pain > 0 1 2 3 4 5 6 7 8 9 10 < Worst pain imaginable		
	Location of pain, if applicable:		
	If pain level is 4 or higher, health care provider will be notified prior to procedure.		
	Optional Form 522 (Request for Administration of Anesthesia) signed and witnessed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Vasectomy performed by:		
Time:	Patient examined prior to discharge by:		
	Post-op vital signs:		
	Anxiety level prior to discharge: <input type="checkbox"/> 1 - Low <input type="checkbox"/> 2 - Medium <input type="checkbox"/> 3 - High		
	If anxiety level is 3, health care provider will be notified prior to discharge.		
	Pain level: No pain > 0 1 2 3 4 5 6 7 8 9 10 < Worst pain imaginable		
	Location of pain, if applicable:		
	If pain level is 4 or higher, health care provider will be notified prior to discharge.		
	Vasectomy post-op instructions reviewed, signed and given to patient.		
Time:	Patient discharged ambulatory in care of:		
	Comments:		
	Discharge vital signs:		
	Discharging nursing personnel signature:		
HOSPITAL OR MEDICAL FACILITY		STATUS	DEPART./SERVICE
SPONSOR'S NAME		SSN/ID NO.	RELATIONSHIP TO SPONSOR
PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)</i>		REGISTER NO.	WARD NO.

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Medical Record
STANDARD FORM 600 (Rev. 6-97)
 Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-9.202.1

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Previous edition is obsolete.